

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009053

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317

Primary Registration District No. 500

Registrar's No. 26

FILED FEB 16 1962

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

1. PLACE OF DEATH a. COUNTY Koch, Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 88 days	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robt. Koch Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1947 Senate Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Oscar		First Carlson	4. DATE OF DEATH Month Jan. Day 2 Year 1962
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-10-84
9. AGE (last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (City and state or country) Sweden
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Carl Carlson- Dec.	
13b. MOTHER'S MAIDEN NAME Catherine ?		14. NAME OF HUSBAND OR WIFE Ida Carlson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Koch Hosp. record, Koch, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia as a complication of Burns Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) of Burns DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Subject also had generalized arteriosclerosis and thrombosis of the right middle cerebral artery (paralysis right side)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Slipped in bath tub with hot water	
20c. TIME OF INJURY 3:30	Hour 3:30 p.m. Month, Day, Year 12/25/61	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bathroom at Koch Hosp		20f. CITY, TOWN, OR LOCATION Koch	
20g. COUNTY St. Louis		20h. STATE Missouri	
21. I attended the deceased from 10-5-61 to 1-2-62 and last saw her alive on 1-2-62 Death occurred at 9:25 A --- m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Axel R. Brown, M.D.	
22b. ADDRESS Robt. Koch Hosp. Koch, Mo.		22c. DATE SIGNED 1-2-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 5, 1962	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR Morrell Mortuary		25. DATE RECD. BY LOCAL REG. 1-4-62	
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Laron E. Percy

Licensed Embalmer No. 4894

P. O. Address S. B. Lewis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.